Denti-Cal

California Medi-Cal Dental Program

Dear Provider:

SUBJECT: REQUEST TO ENROLL IN THE MEDI-CAL DENTAL PROGRAM

Thank you for your request to enroll as a dental provider in the Medi-Cal Dental Program. Attached is the Medi-Cal Dental Provider Number Request form (DC-005) and the Medi-Cal Provider Disclosure Statement of Significant Beneficial Interest form (DC-013).

Prior to acceptance in the Medi-Cal Dental Program the DC-005 and the DC-013 must be completed. In addition, the documents indicated on the attached checklist must also be returned along with your completed application package pursuant to Title 22, California Code of Regulations (Division 3, Chapter 3, Sections 51000.30 and 51000.50) and the Business and Professions Code, Dental Practice Act. **The application package will be returned to you if the application and required documentation is incomplete.**

Please return the completed application package and required documentation to:

Medi-Cal Dental Program
Provider Enrollment
P.O. Box 15609
Sacramento, CA 95852-0609

If you have any questions about the Medi-Cal Dental Program or the information requested, please contact provider toll free line (800) 423-0507.

Sincerely,

Medi-Cal Dental Program
Provider Enrollment

Attachments

Please complete the following required information and/or documents before returning your original Medi-Cal Dental Provider Number Request application package:

Section A: Billing Provider Information:

☐ Box 1 Provider's legal name must be included and match the name on the current dental license.

☐ Box 2 Provide the dental license number and a copy of your dental license issued by the Dental Board of California.

☐ Box 3 If the Taxpayer Identification Number (TIN) of applicant or group is being utilized, please indicate the TIN and submit an official document from the Internal Revenue Service. This information should be consistent with that used when filing State and Federal taxes. Acceptable photocopies of proof can be as follows:

1. The upper portion of Form 941, Employer's Quarterly Federal Tax Return (or preprinted address label from the IRS)
2. IRS letters 147C or SS-4
3. 8109 Deposit Form from the IRS

Provide Social Security Number if Sole Proprietor and not using a TAX ID Number.

☐ Box 4 Return a legible copy of the current Fictitious Name Permit (FNP) issued by the Dental Board of California. This information must be consistent with that used when filing State and Federal taxes.

☐ Box 5 Provide your current telephone number.

☐ Box 6 Provide your billing provider address.

☐ Box 7 Specify type of Business.

1. Individual
2. Partnership: Provide a current copy of the providers Partnership Agreement.
3. Corporation: Provide a current copy of the Articles of Incorporation. This information should be consistent with that used when filing State and Federal income taxes.

Please specify the Type of Practice.

1. Individual
2. Group
3. School/Clinic

Section B: Service Office Information

- ☐ Box 1 Provide the Service Office Address (i.e., Post Office Box or a Commercial Box are not considered service office addresses).
- ☐ Box 2 Provide the Pay-To-Address, if different than the Service Office Address.
- ☐ Box 3 Provide the Service Office Telephone Number (i.e., beeper, answering service, pager, facsimile, cell phone, biller or billing service, or answering machine are not considered business telephone).

Section C: Treating Provider Information

- ☐ Box 1 Provider's legal name must be included and match the name on the current dental license.
- ☐ Box 2 Provide Social Security Number (optional) of treating provider(s).
- ☐ Box 3 Provide the Dental License number and a current copy of your dental license from the Dental Board of California.
- ☐ Box 4 Provide the Narcotics License number (if applicable).
- ☐ Box 5 Provide the Anesthesia Permit number and a current copy issued by the appropriate licensing agency.
- ☐ Box 9 Provide the Billing provider's original signature (blue ink preferred). Photocopies and/or signature stamps are not considered original signatures (no correction fluid).
- ☐ Box 9 Provide the treating provider's original signature (blue ink preferred). Photocopies and/or signature stamps are not considered original signatures (no correction fluid).

Medi-Cal Dental Provider Number Request
Checklist

In addition, pursuant to Title 22, California Code of Regulations, Division 3, Chapter 3, Sections 51000.30 and 51000.50 the following documents are required:

- ☐ Provide a legible copy of each billing and treating provider's driver's license or state-issued identification card number.
- ☐ Provide a copy of the Business License issued by the City or County (if applicable).
- ☐ Provide a copy of the Additional Place of Practice Permit registered with the Dental Board of California and the Additional Service Office Information form (DC-011).
- ☐ Provide a separate completed Medi-Cal Provider Disclosure Statement of Significant Beneficial Interests for each treating provider you are associating to each office. Enclosed you will find the necessary forms for completion. If additional forms are needed, a photocopy is acceptable, **however, original signatures are required (blue ink preferred). Photocopies and/or signature stamps are not considered original signatures.**
- ☐ Do not use correction fluid or correction tape on any of the forms or documents.
- ☐ Signatures must be original, in ink.
- ☐ Other: _____

_____

CRN:

Return to: **Denti-Cal**
Medi-Cal Dental Program
P.O. Box 15609
Sacramento, CA 95852-0609
800 423-0507

MEDI – CAL DENTAL PROVIDER NUMBER REQUEST

IMPORTANT:
- Type or print clearly in ink.
- All items must be completed or marked "N/A".
- Incomplete applications will be returned.
- See back of form for out-of-state rules.

A. BILLING PROVIDER INFORMATION

1. Billing Provider Name (last, first, initial)	2. License Number	3. Tax ID No./SSN
4. "Doing Business As" Attach copy of fictitious name permit	5. Billing Provider Telephone Number	
6. Address		
City / State / ZIP / County		
7. Specify Type of Business ☐ Individual ☐ Partnership ☐ Corporation	Specify Type of Practice ☐ Individual ☐ Group ☐ School/Clinic	

FOR DENTI-CAL USE ONLY

Active
Inactive
R.C.
Date
Oper.
Lic. Date

B. SERVICE OFFICE INFORMATION —

Complete service office/pay to address if different than above. For multiple office/pay-to address, use form DC-011.

1. Service Office Address		2. Pay-To-Address
City / State / ZIP / County		City / State / ZIP
3. Service Office Telephone Number ( )	4. Dental Society	County

C. TREATING PROVIDER INFORMATION —

List all licensed dentists providing services in this service office, including Billing Provider, if applicable. If additional space is needed use form DC-011.

1. Treating Provider Name (last, first, initial)		2. Social Security Number	3. License Number	For DENTI-CAL Use Only
4. Narcotic License	5. Anesthesia Permit	6. Dental Specialty	7. Office Effective Date	A ___ I ___ RC ___ Date ___ Oper ___ Lic. Date ___
1. Treating Provider Name (last, first, initial)		2. Social Security Number	3. License Number	For DENTI-CAL Use Only
4. Narcotic License	5. Anesthesia Permit	6. Dental Specialty	7. Office Effective Date	A ___ I ___ RC ___ Date ___ Oper ___ Lic. Date ___
1. Treating Provider Name (last, first, initial)		2. Social Security Number	3. License Number	For DENTI-CAL Use Only
4. Narcotic License	5. Anesthesia Permit	6. Dental Specialty	7. Office Effective Date	A ___ I ___ RC ___ Date ___ Oper ___ Lic. Date ___

I certify under penalty of perjury that the above information is true, accurate, and complete to the best of my knowledge. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal dental reimbursement and that I must report changes in the above information to the Delta Dental Plan of California, Provider Enrollment Section. I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Denti-Cal Provider Manual. I understand that it is my responsibility to read the manual and its updates.

8. Billing Provider Name (type or print)	9. Billing Provider Signature	10. Date
8. Treating Provider Name (type or print)	9. Treating Provider Signature	10. Date
8. Treating Provider Name (type or print)	9. Treating Provider Signature	10. Date
8. Treating Provider Name (type or print)	9. Treating Provider Signature	10. Date

INSTRUCTIONS

1. All providers intending to bill the Medi-Cal Dental Program (Denti-Cal) or treat Medi-Cal beneficiaries must complete, SIGN, and return the enclosed Medi-Cal Disclosure Statement (DC-013) with this application.

2. Out-of-state providers MUST include copies of all applicable documents issued by your state licensing board.

3. After this application has been reviewed, you will receive a letter of acceptance, a provider manual, and a supply of claim forms from the Denti-Cal Program OR you will receive a letter of rejection with reason(s) thereof.

GENERAL INSTRUCTIONS

Medi-Cal Dental Provider Number Request (DC-005)

CRN: For Denti-Cal use only.

IMPORTANT:

Type or print clearly in ink.

All items must be completed or marked "N/A".

Incomplete applications will be returned.

See back of form for out-of-state rules.

RETURN TO: Return completed applications to Denti-Cal at the address shown.

THE APPLICATION IS DIVIDED INTO THREE PRIMARY PARTS:

A. BILLING PROVIDER INFORMATION

The Billing Provider is identified as the dentist who is billing or requesting authorization for services on the treatment form. In the case of a single practice, the Billing Provider would be the individual practicing dentist. In the case of a group/corporation, school, or clinic, the Billing Provider is the licensed dentist responsible for the practice of the group/corporation, school, or clinic.

1. **Billing Provider Name:** Enter individual dentist name; last name, first name, middle initial.

2. **License Number:** Enter individual license number to practice dentistry issued by the State Board of Dental Examiners.

3. **Tax ID No./SSN:** Enter tax identification number of applicant or group, or Social Security number of applicant. This information should be consistent with that used when filing state and federal taxes.

4. **"Doing Business As":** If the "Doing Business As" (DBA) name is the same as the individual dentist identified in item 1, enter N/A. Enter the business name of a group/corporation, school, or clinic. If enrolling under a fictitious name, a copy of the fictitious name permit, or articles of incorporation showing the fictitious name, must be attached. This information should be consistent with that used when filing state and federal taxes.

5. **Billing Provider Telephone Number:** Enter Billing Provider telephone number, including area code.

6. **Billing Provider Address:** Enter address of Billing Provider, including city, state, ZIP code, and county. This address may be different from the service office address.

7. **Specify Type of Business:** Check one box — "Individual", "Partnership", or "Corporation".

8. **Specify Type of Practice:** Individual — sole practitioner; Group — two or more Treating Providers; School/Clinic — dental school or clinic.

B. SERVICE OFFICE INFORMATION

This area is to be used if the service office (actual place of service) and/or pay-to-address differs from the Billing Provider address indicated in Section "A". If not, enter "N/A" (Not Applicable).

For additional service offices/pay-to addresses, use attached form DC-011. A separate form is required for each additional service office. If additional applications are needed, please copy the documents, including the Medi-Cal Disclosure Statement of Significant Beneficial Interests.

1. **Service Office Address:** Enter address of actual principal practice location, including city, state, ZIP code, and county. A post office box number cannot be used as service office address. In a rural area a route number may be used with a post office box.

2. **Pay-To Address:** Enter information requested if pay-to address differs from actual service address. Post office box numbers may be used.

3. **Service Office Telephone Number:** Enter service office telephone number, including area code.

4. **Dental Society:** Enter name of dental society, if any, of which Billing Provider is a member.

C. TREATING PROVIDER INFORMATION

Treating Provider is identified as any dentist who will be providing services and billing under the Billing Provider's name and provider number. List all licensed dentists providing service at the service office address indicated on this form. The Billing Provider must also be listed if providing services. If additional space is needed, use enclosed form DC-011 or copy the enclosed documents, including the Medi-Cal Disclosure Statement of Significant Beneficial Interests. The Billing Provider and each Treating Provider listed must each sign the form.

1. **Treating Provider Name:** Enter the name of each dentist treating patients at the service office, including Billing Provider, if applicable: last name, first name, middle initial.

2. **Social Security Number:** Enter Social Security number (nine digits) of Treating Provider.

3. **License Number:** Enter individual license number to practice dentistry issued by the State Board of Dental Examiners.

4. **Narcotics License:** Enter Narcotics License number, if applicable.

5. **Anesthesia Permit:** Enter Anesthesia Permit number, if applicable.

6. **Dental Specialty:** Enter dental specialty of Treating Provider.

7. **Office Effective Date:** Enter date on which Treating Provider began to treat patients at service office address.

8. **Billing Provider Name; Treating Provider Name:** Type or print names.

9. **Billing Provider Signature; Treating Provider Signature:** Billing provider and each treating provider must sign the form after reading the certification statement.

10. **Date:** Enter the date the form was read and signed by the billing provider and treating provider(s).

MEDI-CAL PROVIDER DISCLOSURE STATEMENT OF SIGNIFICANT BENEFICIAL INTERESTS

(Instructions on Reverse Side)

Name: _____ Provider License Number: _____

Address: _____

_____

_____

NOTE: EACH BILLING AND TREATING PROVIDER MUST COMPLETE AND SIGN A DISCLOSURE STATEMENT.

NAME OF PROVIDER IN WHICH INTEREST IS HELD	TYPE OF PROVIDER	ADDRESS	NAME OF RELATIVE(S) WHO HOLDS THE INTEREST	RELATION	TYPE OF INTEREST	PERCENTAGE AND/OR DOLLAR AMOUNT OF THE INTEREST

I certify under penalty of perjury that the above information is true, accurate, and complete to the best of my knowledge. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal dental reimbursement and that I must report changes in the above information to the Delta Dental Plan of California, Provider Enrollment Section. I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal Program policies and procedures as published in the Denti-Cal Provider Manual. I understand that it is my responsibility to read the manual and its updates.

Signature _____ Date: _____

RETURN TO: **Denti-Cal**
Medi-Cal Dental Program
P.O. Box 15609
Sacramento, CA 95852-0609
(800) 423-0507

DC-013 (Rev. 7/97)

INSTRUCTIONS

Section 14022 of the Welfare and Institutions Code provides that no payment shall be made to a Medi-Cal provider or to any facility or organization in which he or his immediate family has a "significant beneficial interest" unless the provider has a statement on file disclosing his or the interest his immediate family has in other Medi-Cal providers to which they refer beneficiaries. The applicable section under Medi-Cal program regulations is Section 51466, Article 6, Chapter 3, subdivision 1 of Division 3 of Title 22 of the California Administrative Code. This regulation is shown below.

1. Every provider must complete this form.
2. Disclosure must be made for each member of the provider's immediate family — spouse, parents, spouse's parents, children, and spouses of children.
3. "Significant beneficial interest" means any financial interest that represents either five per cent of the total interest or a value of $25,000 irrespective of the percentage ownership. How different type of interests are to be valued can be determined by referring to Section 51466.
4. If a provider has no "significant beneficial interest" in other providers to which Medi-Cal recipients are referred, place "no interests" on the first line and sign the statement.

51466. Disclosure of Significant Beneficial Interest.

(a) A provider shall not bill or submit a claim for service involving the referral of a beneficiary to or from another provider unless each provider has disclosed any significant beneficial interest existing between the providers. Disclosure shall be accomplished by completing and submitting a Medi-Cal Personal Disclosure Statement of Significant Beneficial Interest form as provided by the Department.

(b) A provider that fails to comply with (a) or that submits a false or incorrect disclosure shall be subject to a suspension from participation or payment under the Medi-Cal program.

(c) For the purpose of this section:

(1) "Significant beneficial interest" means any financial interest held by a provider, or a member of the provider's immediate family, in another provider that is equal to or greater than the lesser of the following:

(A) Five percent of the whole.

(B) $25,000.00.

(2) "Immediate family" means spouse, son, daughter, father, mother, father-in-law, mother-in-law, son-in-law, or daughter-in-law.

(d) Interests held by a provider and members of that provider's immediate family shall be combined and valued as a single interest.

(1) The extent of financial interest shall be determined as follows:

(A) Full ownership shall be considered as 100 per cent financial interest and control regardless of mortgages or other incumbrances.

(B) Interest in a partnership shall be determined on the basis of the percentage of ownership specified in either a written or verbal partnership agreement.

(C) Interest in a corporation shall be determined by computing the percentage of stock or bonds owned or the total outstanding shares or bonds of the corporation as of the last working day of the month preceding compliance with (a).

(D) All other financial arrangements shall require establishment of a fair and reasonable dollar value for both the interest and the whole. The percentage interest shall be computed as the percentage the dollar value of the interest represents of the whole.

(2) The dollar value of the following types of interests shall be determined as follows:

(A) Bonds, over-the-counter stocks and stocks listed on the major stock exchanges shall be valued at the closing selling price on the last working day of the month preceding compliance with (a).

(C) Partnership interests shall be valued at the total dollar amount invested in organizing the partnership. A fair and reasonable dollar equivalent shall be determined if investment is not in form of monies.

(D) All other financial arrangements shall be valued at the actual dollar investment or a fair and reasonable dollar equivalent for investments not in the form of monies.

Dear Provider:

The following information describes the **type of official IRS documents**, which need to be attached to your application. Please send the document that best reflects the way you file your business taxes.

If the applicant (or group) is not using a Social Security Number (SSN)

- √ Please provide the TIN on application and submit an official document from the Internal Revenue Service.
- √ This information must be consistent with that used when filing State and Federal income taxes.
- √ Acceptable photocopies of proof can be as follows:
    1. **The upper portion of Form 941**, Employer's Quarterly Federal Tax Return (or preprinted address label from the IRS)
    2. **147C or SS-4** IRS **Notification letters**
    3. **8109** Deposit Form from the IRS

If the applicant is using a Social Security Number (SSN)

- √ **Please provide the Social Security Number on application and submit Form W-9**.

Form **W-9**
(Rev. January 1993)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give this form to the requester. Do NOT send to IRS.

Please print or type

Name (If joint names, list first and circle the name of the person or entity whose number you enter in Part I below. **See instructions on page 2 if your name has changed.**)

Business name (Sole proprietors see instructions on page 2.) **(If you are exempt from backup withholding, complete this form and enter "EXEMPT" in Part II below.)**

Address (number and street)

List account number(s) here (optional)

City, state, and ZIP code

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). For sole proprietors, see the instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see **How To Obtain a TIN** below.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number

OR

Employer identification number

Part II For Payees Exempt From Backup Withholding (See Exempt Payees and Payments on page 2)

▶

Requester's name and address (optional)

Certification.—Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions.—You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (Also see **Signing the Certification** on page 2.)

Sign Here **Signature ▶** **Date ▶**

Section references are to the Internal Revenue Code.

Purpose of Form.—A person who is required to file an information return with the IRS must obtain your correct TIN to report income paid to you, real estate transactions, mortgage interest you paid, the acquisition or abandonment of secured property, or contributions you made to an IRA. Use Form W-9 to furnish your correct TIN to the requester (the person asking you to furnish your TIN) and, when applicable, (1) to certify that the TIN you are furnishing is correct (or that you are waiting for a number to be issued), (2) to certify that you are not subject to backup withholding, and (3) to claim exemption from backup withholding if you are an exempt payee. Furnishing your correct TIN and making the appropriate certifications will prevent certain payments from being subject to backup withholding.

Note: *If a requester gives you a form other than a W-9 to request your TIN, you must use the requester's form.*

How To Obtain a TIN.—If you do not have a TIN, apply for one immediately. To apply, get **Form SS-5,** Application for a Social Security Card (for individuals), from your local office of the Social Security Administration, or **Form SS-4,** Application for Employer Identification Number (for businesses and all other entities), from your local IRS office.

To complete Form W-9 if you do not have a TIN, write "Applied for" in the space for the TIN in Part I, sign and date the form, and give it to the requester. Generally, you will then have 60 days to obtain a TIN and furnish it to the requester. If the requester does not receive your TIN within 60 days, backup withholding, if applicable, will begin and continue until you furnish your TIN to the requester. For reportable interest or dividend payments, the payer must exercise one of the following options concerning backup withholding during this 60-day period. Under option (1), a payer must backup withhold on any withdrawals you make from your account after 7 business days after the requester receives this form back from you. Under option (2), the payer must backup withhold on any reportable interest or dividend payments made to your account, regardless of whether you make any withdrawals. The backup withholding under option (2) must begin no later than 7 business days after the requester receives this form back. Under option (2), the payer is required to refund the amounts withheld if your certified TIN is received within the 60-day period and you were not subject to backup withholding during that period.

Note: *Writing "Applied for" on the form means that you have already applied for a TIN* ***OR*** *that you intend to apply for one in the near future.*

As soon as you receive your TIN, complete another Form W-9, include your TIN, sign and date the form, and give it to the requester.

What Is Backup Withholding?—Persons making certain payments to you after 1992 are required to withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that could be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee compensation, and certain payments from fishing boat operators, but do not include real estate transactions.

If you give the requester your correct TIN, make the appropriate certifications, and report all your taxable interest and dividends on your tax return, your payments will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. The IRS notifies the requester that you furnished an incorrect TIN, or
3. You are notified by the IRS that you are subject to backup withholding because you failed to report all your interest and dividends on your tax return (for reportable interest and dividends only), or
4. You do not certify to the requester that you are not subject to backup withholding under 3 above (for reportable interest and dividend accounts opened after 1983 only), or
5. You do not certify your TIN. This applies only to reportable interest, dividend, broker, or barter exchange accounts opened after 1983, or broker accounts considered inactive in 1983.

Except as explained in 5 above, other reportable payments are subject to backup withholding only if 1 or 2 above applies. Certain payees and payments are exempt from backup withholding and information reporting. See **Payees and Payments Exempt From**

Backup Withholding, below, and **Exempt Payees and Payments** under **Specific Instructions,** below, if you are an exempt payee.

Payees and Payments Exempt From Backup Withholding.—The following is a list of payees exempt from backup withholding and for which no information reporting is required. For interest and dividends, all listed payees are exempt except item (9). For broker transactions, payees listed in (1) through (13) and a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker are exempt. Payments subject to reporting under sections 6041 and 6041A are generally exempt from backup withholding only if made to payees described in items (1) through (7), except a corporation that provides medical and health care services or bills and collects payments for such services is not exempt from backup withholding or information reporting. Only payees described in items (2) through (6) are exempt from backup withholding for barter exchange transactions, patronage dividends, and payments by certain fishing boat operators.

(1) A corporation. **(2)** An organization exempt from tax under section 501(a), or an IRA, or a custodial account under section 403(b)(7). **(3)** The United States or any of its agencies or instrumentalities. **(4)** A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities. **(5)** A foreign government or any of its political subdivisions, agencies, or instrumentalities. **(6)** An international organization or any of its agencies or instrumentalities. **(7)** A foreign central bank of issue. **(8)** A dealer in securities or commodities required to register in the United States or a possession of the United States. **(9)** A futures commission merchant registered with the Commodity Futures Trading Commission. **(10)** A real estate investment trust. **(11)** An entity registered at all times during the tax year under the Investment Company Act of 1940. **(12)** A common trust fund operated by a bank under section 584(a). **(13)** A financial institution. **(14)** A middleman known in the investment community as a nominee or listed in the most recent publication of the American Society of Corporate Secretaries, Inc., Nominee List. **(15)** A trust exempt from tax under section 664 or described in section 4947.

Payments of **dividends** and **patronage dividends** generally not subject to backup withholding include the following:

- Payments to nonresident aliens subject to withholding under section 1441.
- Payments to partnerships not engaged in a trade or business in the United States and that have at least one nonresident partner.
- Payments of patronage dividends not paid in money.
- Payments made by certain foreign organizations.

Payments of **interest** generally not subject to backup withholding include the following:

- Payments of interest on obligations issued by individuals.

Note: *You may be subject to backup withholding if this interest is $600 or more and is paid in the course of the payer's trade or business and you have not provided your correct TIN to the payer.*

- Payments of tax-exempt interest (including exempt-interest dividends under section 852).
- Payments described in section 6049(b)(5) to nonresident aliens.
- Payments on tax-free covenant bonds under section 1451.
- Payments made by certain foreign organizations.
- Mortgage interest paid by you.

Payments that are not subject to information reporting are also not subject to backup withholding. For details, see sections 6041, 6041A(a), 6042, 6044, 6045, 6049, 6050A, and 6050N, and their regulations.

Penalties

Failure To Furnish TIN.—If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil Penalty for False Information With Respect to Withholding.—If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal Penalty for Falsifying Information.—Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs.—If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name.—If you are an individual, you must generally provide the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, please enter your first name, the last name shown on your social security card, and your new last name.

If you are a sole proprietor, you must furnish your **individual** name and either your SSN or EIN. You may also enter your business name or "doing business as" name on the business name line. Enter your name(s) as shown on your social security card and/or as it was used to apply for your EIN on Form SS-4.

Signing the Certification.—

1. Interest, Dividend, and Barter Exchange Accounts Opened Before 1984 and Broker Accounts Considered Active During 1983. You are required to furnish your correct TIN, but you are not required to sign the certification.

2. Interest, Dividend, Broker, and Barter Exchange Accounts Opened After 1983 and Broker Accounts Considered Inactive During 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.

3. Real Estate Transactions. You must sign the certification. You may cross out item **2** of the certification.

4. Other Payments. You are required to furnish your correct TIN, but you are not required to sign the certification unless you have been notified of an incorrect TIN. Other payments include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services, payments to a nonemployee for services (including attorney and accounting fees), and payments to certain fishing boat crew members.

5. Mortgage Interest Paid by You, Acquisition or Abandonment of Secured Property, or IRA Contributions. You are required to furnish your correct TIN, but you are not required to sign the certification.

6. Exempt Payees and Payments. If you are exempt from backup withholding, you should complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "EXEMPT" in the block in Part II, and sign and date the form. If you are a nonresident alien or foreign entity not subject to backup withholding, give the requester a completed **Form W-8,** Certificate of Foreign Status.

7. TIN "Applied for." Follow the instructions under **How To Obtain a TIN,** on page 1, and sign and date this form.

Signature.—For a joint account, only the person whose TIN is shown in Part I should sign.

Privacy Act Notice.—Section 6109 requires you to furnish your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, or contributions you made to an IRA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not furnish a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish.

[2] Circle the minor's name and furnish the minor's SSN.

[3] Show your individual name. You may also enter your business name. You may use your SSN or EIN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when there is more than one name, the number will be considered to be that of the first name listed.*

*U.S. Government Printing Office: 1993 — 343-034/80026

Denti-Cal

California Medi-Cal Dental Program

Medi-Cal Dental Provider Survey Follow-up

Dear Doctor:

The Denti-Cal patient referral service has been implemented and is now serving the dental community statewide. In completing your application to become a Denti-Cal Provider, at your request your name can be added to our referral list for new Denti-Cal patients.

We again ask that you assist us by completing the form below and returning it to Denti-Cal in the enclosed envelope. Please be reminded that your participation in this patient referral service would be appreciated; however, an indication that your office does not wish to be placed on our referral list will not affect your current status as an enrolled Denti-Cal provider.

Thank you for your support and in the Medi-Cal Dental Program. If you have any questions about the Denti-Cal patient referral service, please do not hesitate to call us toll-free (800) 322-6384.

Sincerely,
Denti-Cal Beneficiary Services Group

Medi-Cal Dental Program
Patient Referral Service

☐ Yes I would like new Denti-Cal patients referred to my office. Please add my name to your referral list. I understand I may request removal of my name from this at anytime.

☐ No I do not want new Denti-Cal patients referred to my office. Please do not add my name to your referral list.

(please type or print clearly)

Dentist's Name: _____ License # _____

DBA Name: _____

Office Address: _____

_____

Telephone Number: ( )_____

Signature: _____

DC 153 (11/00)

ORTHODONTIA PROVIDER CERTIFICATION

Name: _____

Provider Number: _____

By initialing the applicable items listed below and signing this form, I certify that I meet the (Section 51223) Title 22 requirements for a 'qualified orthodontist'. I understand that I am required to complete and submit this certification as a prerequisite for providing orthodontic services for handicapping malocclusion to eligible Med-Cal beneficiaries.

1. ☐ I confine my practice to the specialty of orthodontics.

and (at least one of the following)

2. ☐ I have successfully completed a course of advanced study in orthodontics of two years or more in programs recognized by the Council on Dental Education of the American Dental Association.

or

3. ☐ I have completed advanced training in orthodontics prior to July 1, 1969 and am a member of or eligible for membership in the American Association of Orthodontists.

_____

Signature Date

PROOF OF COURSE COMPLETION
(As defined in #2 and #3)
MUST BE ATTACHED

CALIFORNIA MEDI-CAL PROGRAM
ORTHODONTIC PATIENT REFERRAL SERVICE

☐ Yes, I would like new Denti-Cal orthodontic patients referred to my office. Please add my name to your referral list I under stand I may request removal of my name from this list at any time.

☐ No, I do not want new Denti-Cal orthodontic patients referred to my office. Please do not add my name to your referrals list.

(please type or print clearly)

Billing Dentist's Name:_____ Provider Number:_____

DBA Name: _____

Office Address: _____

_____

Telephone Number: (_____) _____

Does your office have wheelchair access? ☐ Yes ☐ No

Please indicate the language(s) spoken in your office. _____

Does your office have evening or Saturday hours? ☐ Yes ☐ No
If yes, Please specify hours: _____

Comments: _____

_____

_____

_____

Signature: _____ Date: _____

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 18, NUMBER 12 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JUNE, 2002

PROGRAM ENROLLMENT

This bulletin contains the requirements for participation in the Medi-Cal Dental Program. The California Medi-Cal Dental Program requires that all dentists must be enrolled in the Medi-Cal Dental Program prior to treating Medi-Cal patients. State and Federal guidelines must be followed, pursuant to Title 22 California Code of Regulations (Division 3, Chapter 3, Sections 51000.30 through 51000.50), Business and Professions Code, Dental Practice Act, and IRS laws and regulations.

1. Medi-Cal Dental Provider Number Request (DC-005)

The Medi-Cal Dental Provider Number Request (DC-005) form and the Medi-Cal Provider Disclosure Statement of Significant Beneficiary Interests (DC-013) form are required to request any of the following actions:

- Individual dental provider with sole ownership, requesting to apply for a Medi-Cal Dental billing provider number.
- Individual dental provider with a current Medi-Cal billing provider number, requesting to add an additional place of practice, utilizing a different Tax Identification Number (TIN).
- Individual dental provider with a current Medi-Cal billing provider number, requesting to add an additional place of practice as a new corporation and/or new partnership.
- A current Medi-Cal dental billing provider, with sole ownership, requesting to add rendering provider(s).
- Schools, clinics and universities requesting to open a new practice.
- Non-profit organizations, new mobile practices and out of state dentists opening a new place of practice, requesting to apply for a Medi-Cal Dental billing provider number.
- Two or more dentists working in the same location, requesting to enroll as a group provider.
- Currently enrolled group practice, changing the enrollment status, for example:
  - Dissolution of partnership;
  - A change from sole proprietor to partnership;
  - A change from group to single practice.

It is the responsibility of each Medi-Cal Dental Program billing provider to enroll all rendering providers in each service office. If an un-enrolled rendering provider performs services on a Medi-Cal beneficiary, payment for those services billed will be denied.

The following documents must be returned along with the completed application package:

- Dental License(s) issued by the Dental Board of California (DBC) (mandatory);
- Driver's license number or state-issued identification card for all rendering providers (mandatory);
- Medi-Cal Provider Disclosure Statement of Significant Beneficial Interests (DC-013) form (include copies of driver's license number or state-issued identification card of providers/ business owners with five percent or more controlling interest in the dental practice) (mandatory);

- Federal Employer Identification Number (EIN) or Tax Identification Number (TIN) (Form 941, 147-C, SS-4, 2363, or 8109C) (if applicable);
- Form W-9 (only required if filing taxes with a Social Security Number (SSN));
- Fictitious Name Permit (if applicable);
- Articles of incorporation (if applicable);
- Partnership Agreement (if applicable);
- Business License issued by the city or county (if applicable).

2. **Additional Service Office Information (DC-011)**

All Medi-Cal Dental program providers are required to notify the California Medi-Cal Dental Program when making the following changes to their existing practice or type of business:

- Sole proprietor, adding additional service office location(s) with no change to the existing practice or type of business
- Group provider, adding additional service office location(s) with no change to the existing practice or type of business

The Additional Service Office Information (DC-011) form, along with the following documents must be returned along with the completed DC-011 application package:

- Medi-Cal Dental Provider Number Request (DC-005);
- Additional Service Office Permit (issued by the Dental Board of California);
- Dental License(s) issued by the Dental Board of California (DBC) (mandatory);
- Driver's license number or state-issued identification card for each rendering provider(s) (mandatory);
- Medi-Cal Provider Disclosure Statement of Significant Beneficial Interests (DC-013) form (include copies of driver's license number or state-issued identification card of providers/ business owners with five percent or more controlling interest in the dental practice) (mandatory);
- Federal Employer Identification Number (EIN) or Tax Identification Number (TIN) (Form 941, 147-C, SS-4, 2363, or 8109C) (if applicable);
- Form W-9 (only required if filing taxes with a Social Security Number (SSN));
- Fictitious Name Permit (if applicable);
- Articles of incorporation (if applicable);
- Partnership Agreement (if applicable);
- Business License issued by the city or county (if applicable).

3. **Medi-Cal Dental Provider Information Change/Deletion Request (DC-012)**

The Medi-Cal Dental Provider Information Change/Deletion Request (DC-012) form is required when making the following changes to an existing Medi-Cal billing provider number:

- Change of service office address, telephone and/or pay to address
- Group practice(s) adding/or deleting a rendering provider to a service office
- Change to the Tax Identification Number (TIN) or Employer Identification Number (EIN). (Submit a current copy of official Internal Revenue Service (IRS) document to verify your name and TIN). (Business name must match name on the document(s).)
- Change of Business Name (if incorporated, submit a copy of the Articles of Incorporation verifying the name of the corporation. If said corporation is doing business under a fictitious name, a copy of the Fictitious Name Permit issued by the Dental Board of California must also be attached). (Name must match name on the document(s).)

Do not complete the DC-012 if you are making a change that involves proprietorship, partnership, corporation or a change to the type of practice. A Medi-Cal Dental Provider Number Request (DC-005) form must be completed for these types of actions.

4. **Dental Board of California Requirements**
   Fictitious Name Permit

   Effective July 1, 1995, all dentists using a "Doing Business As (DBA)" name are required to obtain a fictitious name permit issued by the Dental Board of California. Only licensed dentists in good standing are issued a fictitious name permit. The permit is renewable every two years and coincides with the dental license renewal date of the permit holder. Prior to submitting your application to the Medi-Cal Dental Program, direct all questions regarding the use of a name for your practice to the Dental Board of California.

   The Dental Board of California and the California Medi-Cal Dental Program must be contacted when making any of the following changes to your business:
   - Any change of address from that specified on the permit
   - Any change to the name specified on the permit (including sale of practice and a new owner)
   - Dissolution of partnership
   - A change from sole proprietor (single practice) to partnership (group practice)
   - A change from partnership (group practice) to sole proprietor (single practice)
   - Transfer same fictitious name to a new permit number
   - If filing as a corporation, submit a current copy of the Articles of Incorporation as registered with the Secretary of State

5. **Continued Enrollment in the Medi-Cal Dental Program**

   In order to remain an active provider in the Medi-Cal Dental Program, providers must continue to meet all requirements of the *Dental Practice Act* (refer to section *Dental Practice Act, Business and Professions Code Article 2. Admission and Practice*) and the requirements set forth in Title 22 Federal Regulations.

   Billing and rendering providers will automatically be inactivated from the Medi-Cal Dental Program if any of the following occurs:
   - Dental license is expired, revoked, inactivated, denied renewal, or suspended by the Dental Board of California
   - Twelve months with no claim activity in the Medi-Cal Dental Program
   - Mail is returned by the post office marked "Undeliverable" due to incorrect address
   - A rendering provider is not associated with an active billing provider

   Upon inactivation, providers will be required to re-enroll in the Medi-Cal Dental Program.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 16, NUMBER 16 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 SEPTEMBER, 2000

DENTI-CAL CHANGES:

- **INCREASE IN DENTI-CAL REIMBURSEMENT RATES**
- **CHANGES IN SCOPE OF BENEFITS FOR PERIODIC EVALUATION AND PROPHYLAXES**

The Department of Health Services has announced an increase in the reimbursement rates and benefit changes for dental procedures under the California Medi-Cal Dental Program, effective August 1, 2000. Denti-Cal is in the process of updating the claims processing system and preparing to make adjustments to documents already processed.

Rate Increase

This rate increase primarily targets children's and specialty procedures. Denti-Cal claims, having dates of service August 1, 2000 and after, will be paid in accordance with the new rates.

For claims already processed, Denti-Cal is scheduling automatic retroactive adjustments. Providers will receive a retroactive reimbursement check and Explanation of Benefits for those procedures rendered after August 1, 2000. Please **do not** submit Claim Inquiry Forms (CIF) or Notices of Authorization (NOA) for reevaluation to receive additional reimbursement. It is anticipated that the retroactive reprocessing will be completed by November 1, 2000. To receive the most current allowance for Denti-Cal procedures, providers are reminded to always use their Usual and Customary Fees when submitting for payment.

Benefit Changes

The new scope of benefits allows for Periodic Oral Evaluation and Prophylaxes every six months. The system to reimburse for these new benefits is not in place at this time; therefore, **do not** submit these new procedures for payment until notified.

The enclosed schedule indicates the reimbursement rates to be applied to all Denti-Cal services performed on or after August 1, 2000 and highlights the new rates.

If you have any questions about the new rates, please call Denti-Cal toll-free at (800) 423-0507.

DENTI-CAL SCHEDULE OF MAXIMUM ALLOWANCES

Effective August 1, 2000

1. Fees payable to providers by Denti-Cal for covered services shall be LESSER of:
   a. the fee charged by the provider
   b. the charges for dental services shall be reimbursed in accordance with the Department of Health Services maximum reimbursement rates as follows
   c. the maximum allowance set forth in the schedule below
2. Procedures limited to children (under age 18) are indicated by an asterisk(*).
3. Refer to your Denti-Cal Handbook for specific procedure instructions and program limitations.

Procedure Number	Procedure	Maximum Allowance ($)
Visits – Diagnostic (000-199)		
010	Examination, initial episode of treatment only	25.00
015	Evaluation, periodic	15.00
020	Office visit during regular office hours for Treatment and observation of injuries to the teeth and supporting structures	20.00
030	Professional visit after regular office hours, or to bedside	35.00
035	Hospital Care	50.00
040	Specialist Consultation	35.00
045	Pit and Fissure Dental Sealants for Permanent First Molars, to age twenty-one (21)	22.00
046	Pit and Fissure Dental Sealants for Permanent Second Molars, to age twenty-one (21)	22.00
049*	Prophylaxis, beneficiaries through age 12	30.00
050	Prophylaxis, beneficiaries age 13 years and older	40.00
061*	Prophylaxis, including topical application of fluoride—Beneficiaries age 5 and under	35.00
062*	Prophylaxis, including topical application of fluoride –Beneficiaries age 6 through 17	40.00
080	Emergency Treatment, palliative	45.00
110	Intraoral periapical,, single, first film	10.00
111	Intraoral periapical, each additional film (maximum 10 films)	3.00
112	Intraoral, complete series consisting of at least 14 periapical films plus bitewings	45.00
113	Intraoral, occlusal, each film	10.00
114	Extraoral, single, head or lateral jaw	22.00
115	Extraoral, each additional, head or lateral jaw	5.00
116	Bitewings, two films	10.00
117	Bitewings, four films	18.00
118	Bitewing, anterior, one film	5.00
119	Photograph or slide, first	7.00
120	Photograph or slide, each additional (maximum 5)	3.00
125	Panographic-type film, single film	25.00
150	Biopsy of oral tissue	100.00
160	Gross and microscopic histopathological report	50.00
Oral Surgery (200-299)		
200	Removal of erupted tooth, uncomplicated, first tooth	45.00
201	Removal of erupted tooth, uncomplicated, each additional tooth	38.00
202	Removal of erupted tooth, surgical	85.00
203	Removal of root or root tip, completely covered by bone	100.00
204	Removal of root or root tip, not completely covered by bone	40.00
220	Postoperative visit, complications (e.g., osteitis)	15.00
230	Removal of impacted tooth – soft tissue	100.00
231	Removal of impacted tooth – partially bony	135.00
232	Removal of impacted tooth – completely bony	165.00
250	Alveoloplasty per quadrant, edentulous	100.00
252	Alveoloplasty per quadrant, in conjunction with extractions	50.00
255	Vestibuloplasty, submucosal resection (not to include grafts)	400.00
256	Alveoloplasty with ridge extension, secondary epithelialization (per arch)	200.00
257	Removal of palatal exostosis (torus)	200.00
258	Removal of mandibular exostosis (torus) per quadrant	100.00
259	Excision of hyperplastic tissue (per arch)	100.00
260	Incision and drainage of abscess, intraoral	50.00
261	Incision and drainage of abscess, extraoral	75.00
262	Excision pericoronal gingiva, operculectomy	50.00
263	Sialolithotomy intraoral	235.00
264	Sialolithotomy extraoral	300.00
265	Closure of salivary fistula	120.00
266	Dilation of salivary duct	120.00
267	Reduction of tuberosity, unilateral	75.00
269	Excision of benign tumor, up to 1.25 cm	100.00
270	Excision of benign tumor, larger than 1.25 cm	250.00

Procedure Number	Procedure	Maximum Allowance ($)
271	Excision of malignant tumor	325.00
273	Reimplantation and/or stabilization of accidentally evulsed or displaced permanent tooth and/or alveolus	175.00
275*	Transplantation of tooth or tooth bud	1000.00
276	Removal of foreign body from bone (independent procedure)	130.00
277	Radical resection of bone for tumor with bone graft	1200.00
278	Maxillary sinusotomy for removal of tooth fraction or foreign body	380.00
279	Oral—antral fistula closure	300.00
280	Excision of cyst, up to 1.25 cm	100.00
281	Excision of cyst, over 1.25 cm	200.00
282	Sequestrectomy	100.00
285	Condylectomy of mandible, unilateral	1000.00
289	Menisectomy of temporomandibular joint, unilateral	1000.00
290	Excision of foreign body, soft tissue	60.00
291	Frenectomy, or frenotomy, separate procedure	100.00
292	Suture of soft tissue wound or injury	50.00
294	Injection of sclerosing agent into temporomandibular joint	75.00
295	Injection of trigeminal nerve branches for destruction	200.00
296	Surgical exposure of impacted or unerupted tooth to aid eruption, soft tissues	100.00
297	Surgical exposure of impacted or unerupted tooth to aid eruption, partially bony	135.00
298	Surgical exposure of impacted or unerupted tooth to aid eruption, completely bony or ectopic eruption	135.00
299	Unlisted surgical service or procedure	By Report
Drugs and Anesthesia (300-400)		
300	Injectable drugs	15.00
301	Conscious sedation relative analgesia (nitrous oxide) per visit	25.00
400	General anesthesia	100.00
Periodontics (450-499)		
451	Emergency treatment (periodontal abscess, Acute periodontitis, etc.)	55.00
452	Subgingival curettage and root planing per treatment	200.00
453	Occlusal adjustment (limited) per quadrant (minor spot grinding	25.00
472	Gingivectomy or gingivoplasty per quadrant	166.00
473	Osseous and mucogingival surgery per quadrant	350.00
474	Gingivectomy, or gingivoplasty, treatment per tooth (fewer than six teeth)	50.00
Endodontics (500-599)		
501	Therapeutic pulpotomy	71.00
502	Vital pulpotomy	71.00
503	Recalcification, includes temporary restoration, per tooth	41.00
511	Anterior root canal therapy	215.00
512	Bicuspid root canal therapy	260.00
513	Molar root canal therapy	330.00
530	Apicoectomy—surgical procedure in conjunction with root canal therapy	300.00
531	Apicoectomy (separate surgical procedure), per tooth	100.00
534	Apexification/apexogenesis (therapeutic apical closure), per treatment	100.00
Restorative Dentistry (600-679)		
Amalgam Restorations		
600*	One surface, primary tooth	35.00
601*	Two surfaces, primary tooth	43.00
602*	Three surfaces, primary tooth	50.00
603*	Four or more surfaces, primary tooth (maximum)	57.00
611	One surface, permanent tooth	39.00
612	Two surfaces, permanent tooth	48.00
613	Three surfaces, permanent tooth	57.00
614	Four or more surfaces, permanent tooth (maximum)	60.00
Silicate, Composite, Plastic Restorations		
640	Silicate cement restoration	0.00
641	Silicate restorations, two or more in a single tooth (maximum)	0.00
645	Composite or plastic restoration	55.00
646	Composite or plastic restorations two or more in a single tooth (maximum)	85.00
648	Pin retention (per pin) maximum three pins per tooth	80.00
Crowns		
650	Crown, plastic (laboratory processed)	150.00
651	Crown, plastic with metal	220.00
652	Crown, porcelain	375.00
653	Crown, porcelain fused to metal	340.00
660	Crown, cast full	340.00
663	Crown, cast, three quarters	375.00
670*	Crown, stainless steel (primary)	75.00
671	Crown, stainless steel (permanent)	90.00
672	Cast metal dowel post	75.00
Prosthetics (680-799)		
Pontics		
680	Fixed bridge pontic, cast metal	325.00
681	Fixed bridge pontic, slotted facing	325.00
682	Fixed bridge pontic, slotted pontic	325.00
692	Fixed bridge pontic, porcelain fused to metal	325.00
693	Fixed bridge pontic, plastic processed to metal	325.00
Recementation		
685	Recement inlay, facing, pontic	30.00
686	Recement crown	30.00
687	Recement bridge	50.00
Repairs, Crown, and Bridge		
690	Repair fixed bridge	By Report
694	Replace broken tru-pontic	75.00
695	Replace broken facing, post intact	75.00
696	Replace broken facing, post backing broken	75.00
Removal Prosthodontics		
700	Complete maxillary denture	450.00

Procedure Number	Procedure	Maximum Allowance ($)
701	Complete mandibular denture	450.00
702	Partial upper or lower denture with two assembled chrome cobalt wrought or cast chrome cobalt clasps with occlusal rests and necessary teeth, acrylic base	415.00
703	Partial upper or lower denture with cast chrome cobalt skeleton, two cast clasps, and necessary teeth	400.00
704	Clasps, third and each additional clasp for Procedure 703	40.00
705	Stress breakers, extra	40.00
706	Partial upper or lower stayplate, acrylic-base fee, teeth and clasps extra	150.00
708	Partial upper or lower denture, all acrylic with two assembled chrome cobalt wrought clasps having two clasp arms, but no rests, and necessary teeth	275.00
709	Clasp, third and each additional for Procedure 708	25.00
712	Clasp, third and each additional for Procedure 702	25.00
716	Clasp or teeth, each for Procedure 706	23.00
720	Denture adjustment, per visit	25.00
721	Reline—office, cold cure	70.00
722	Reline—laboratory processed	140.00
723	Tissue conditioning, per denture	50.00
724	Denture duplication ("jump," "reconstruction") denture base including necessary tooth replacement, per denture	150.00

Repairs, Dentures, Acrylic

750	Repair broken denture base only (complete or partial)	45.00
751	Repair broken denture and replace one broken denture tooth	65.00
752	Each additional denture tooth replaced on 751 repair (maximum two)	15.00
753	Replace one broken denture tooth on 751 repair (complete or partial)	50.00
754	Each additional denture tooth replaced on 753 repair (maximum two)	15.00
755	Adding first tooth to partial denture to replace newly extracted natural tooth	65.00
756	Each additional natural tooth replaced on 755 repair (maximum two)	30.00
757	Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 702 partial denture	75.00
758	Each additional new or replacement clasp for repair 757 (maximum two)	75.00
759	Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 708 partial denture	75.00
760	Each additional new or replacement clasp for repair 759 (maximum two)	50.00
761	Reattaching clasp on partial denture, clasp intact, each (maximum two)	60.00
762	Add a new or replace a broken cast chrome Cobalt clasp with two clasp arms and rest to an existing 703 partial denture	75.00
763	Each additional new or replacement clasp for repair 762 (maximum two)	75.00

Space Maintainers (800-899)

800	Fixed, unilateral band type (including band)	120.00
801	Removable, plastic, with two stainless steel round wire clasps or rests	230.00
802	Each additional clap or rest (for 801 only)	15.00
811	Fixed, unilateral stainless steel crown type (including crown, Procedure 670 or 671)	111.00
812	Fixed, bilateral, lingual or palatal bar type	200.00
832	Fixed or removable appliance to control harmful habit	221.00

Fractures and Dislocations (900-949)

(includes usual follow-up care)

900	Maxilla, open reduction, simple	1000.00
901	Maxilla, closed reduction, simple	500.00
902	Mandible, open reduction, simple	1200.00
903	Mandible, closed reduction, simple	700.00
904	Maxilla, closed reduction, compound	800.00
905	Maxilla, open reduction, compound	1200.00
906	Mandible, closed reduction, compound	800.00
907	Mandible, open reduction, compound	1200.00
913	Reduction of dislocation of Temporomandibular joint	140.00
915	Treatment of malar fracture, simple; closed Reduction	250.00
916	Treatment of malar fracture, simple or Compound depressed, open reduction	500.00

Unlisted Procedures

999	Fees to be determined by Report	

DENTI-CAL SCHEDULE OF MAXILLOFACIAL DENTAL SERVICES

Effective August 1, 2000

1. Fees payable to providers by Denti-Cal for covered services shall be the LESSER of:
   a. the fee charged by the provider
   b. maximum allowances or
   c. the maximum allowance set forth in the schedule below

Procedure Number	Procedure	Maximum Allowance ($)
Diagnostic Services (950-957)		
950	Clinical examination and consultation, including study models	100.00
952	Prosthetic evaluation and treatment plan, including study models	100.00
955	TMJ series radiographs	100.00
956	Cephalometric head film, single, first film, including tracing	50.00
957	Cephalometric head film, each additional film, including tracing	10.00
Maxillofacial Prosthetic Services (960-982)		
960	Speech appliance, transitional, with or without pharyngeal extension	800.00
962	Speech appliance, permanent, edentulous, with or without pharyngealextension	1400.00
964	Speech appliance, permanent, partially edentulous, cast framework, with or without pharyngeal extension	1500.00
966	Palatal lift, interim	800.00
968	Palatal lift permanent, cast framework	1400.00
970	Obturator, immediate surgical routine	900.00
971	Obturator, immediate surgical complex	1200.00
972	Obturator, permanent, complex	1500.00
973	Resection prosthesis, permanent, edentulous, complex	1500.00
974	Resection prosthesis, permanent, edentulous, routine	1400.00
975	Resection prosthesis, permanent, partially edentulous, complex	1700.00
976	Repositioner, mandibular, two piece	2300.00
977	Removable facial prosthesis	By Report
978	Splints and stents	By Report
979	Radiation therapy fluoride carrier	80.00
980	Repairs, maxillofacial prosthesis	By Report
981	Rebase laboratory processed, maxillofacial prosthesis	By Report
982	Balancing (opposing) maxillofacial prosthesis	By Report
Maxillofacial Surgical Procedures		
985	Maxillofacial surgical procedures	By Report
Temporomandibular Joint Dysfunction Management (990-998)		
990	Occlusal analysis, including report and/or models	180.00
992	Occlusal adjustments, limited centric and excursive adjustments,including records and/or models	90.00
994	Occlusal balancing, altering centric relation, including records and/or models	400.00
995	Orthopedic stabilizing appliance, disocclusion splint	300.00
996	Postoperative visits, symptomatic care and counseling	75.00
998	Unlisted therapeutic service	By Report

DENTI-CAL SCHEDULE OF CLEFT PALATE ORTHODONTIC SERVICES

Effective August 1, 2000

1. Reimbursement for orthodontic dental services in the treatment of handicapping malocclusion and cleft palate deformities shall be the usual charge to the general public, not to exceed the maximum reimbursement rate listed.
2. Maximum allowances.

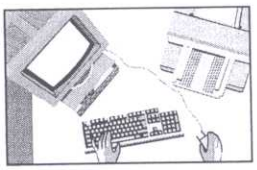
Procedure Number	Procedure	Maximum Allowance ($)
Malocclusion Cases (551-558)		
551	Initial Orthodontic Examination/Handicapping Labio-Lingual Deviation Index	35.00
552	Banding and materials	650.00
554	Per treatment visit24 months maximum. One visit maximum per calendar month	70.00
556	Quarterly observation 6 quarters maximum	50.00
557	Diagnostic work-up and photographs (additional dental services are listed separately in Section 51506(b), procedure 112Intraoral, complete series; and Section 51506.1(b), procedure codes 956 and 957 cephalometric head films, including tracing)	100.00
558	Study models	75.00
Cleft Palate Cases (560-582)		
Primary Dentition		
560	Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 112, and cephalometric head films, procedure codes 956 and 957 including tracing, are separately payable at State fee schedule)	200.00
562	Banding and materials	300.00
564	Per treatment visit - 10 visits maximum, one visit per calendar month	50.00
Mixed Dentition		
570	Banding and materials	500.00
572	Per treatment visit - 14 visits maximum. One visit maximum per calendar month	50.00
Permanent Dentition		
580	Banding and materials	800.00
582	Per treatment visit - 30 visits maximum. One visit per calendar month	100.00

Procedure Number	Procedure	Maximum Allowance ($)
Facial Growth Management (590-598)		
590	Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 112, and cephalometric head films, procedure codes 956 and 957 including tracing, are separately payable at State fee schedule)	100.00
592	Quarterly observation, maximum 6 quarters	50.00
594	Progress records prior to treatment	100.00
596	Banding and materials	800.00
598	Per treatment visit24 visits maximum. One visit maximum per calendar month	100.00
Malocclusion, Cleft Palate and Facial Growth Management Cases – Retention (556-599)		
556	Quarterly observation 6 quarters maximum	50.00
599	Retainer, removable, for each upper and lower	200.00

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 16, SPECIAL EDITION P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 NOVEMBER, 2000

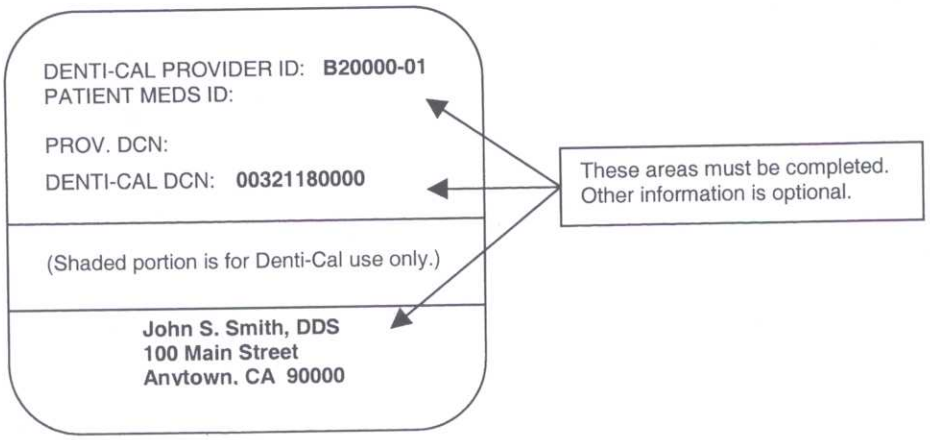


Learn About Electronic Claims Submission!

ELECTRONIC DATA INTERCHANGE (EDI) LABELS – HELPFUL HINTS

To ensure that your electronically submitted documents are linked to your x-rays and attachments correctly and processed as quickly as possible, here are a few tips:

- Submit EDI labels only when they are requested on Denti-Cal's X-Ray/Attachment Request (report ID# CP-O-971-P).
- Please do not affix labels to Resubmission Turnaround Documents (RTDs) or Notices of Authorization (NOAs).
- Only one Document Control Number (DCN) can be written on an EDI label. If you want to submit films associated with more than one DCN, up to two labels for the same patient may be affixed side-by-side on an EDI envelope.
- Duplicate EDI labels submitted with duplicated x-rays for documents that have already been processed will be returned to you.
- Three areas on EDI labels must be completed: your Denti-Cal Provider ID, Denti-Cal's eleven-digit Document Control Number (also referred to as the Base DCN), and your name and address. Labels that do not have this information will be returned to you for completion. Other information is helpful, but is not required.



- Labels can be ordered partially preprinted with your Denti-Cal Provider ID#, name and address so you only need to hand write the Denti-Cal DCN. To order these labels (Order Number DC-018A, type B), use the EDI Supply Request form (Denti-Cal 139).

For additional information, please contact EDI Support at (916) 853-7373 extension 2450 or 2451.